CLAY COUNTY SCHOOLS
Student's Profile Sheet

Child's Name _____ Bus No. _____ WVEIS No. _____
Last, First Middle

Grade _____ Sex _____ Date of Birth _____ Place of Birth _____

Child's Mailing Address _____
Street or PO Box, City, State Zip

Child's Physical Address _____

Telephone (Parent/Guardian) _____ Work Telephone Number _____

Emergency Contact _____ Telephone Number _____

Father's Name _____ Mother's Name _____
Please circle. Living Deceased Divorced Please circle. Living Deceased Divorced

Step-Father's Name _____ Legal Guardian's Name(s) _____

Step-Mother's Name _____ Foster Parent Name(s) _____

Name of person with whom student lives _____

Does your child require Special Education Services? YES _____ NO _____

HEALTH HISTORY
Does your child have any of the following conditions?

_____ Allergies	_____ Cystic Fibrosis	_____ Hyperactive/ADHD	_____ Seizure/Epilepsy
_____ Anorexia/Bulimia	_____ Depression	_____ Intestinal problems	_____ Spina Bifida
_____ Arthritis	_____ Diabetes	_____ Leukemia	_____ Sports injury/Fractures
_____ Asthma	_____ Ear infections	_____ Multiple Sclerosis	_____ Thyroid disease
_____ Bladder infections	_____ Emotional problems	_____ Pneumonia	_____ Tourette's syndrome
_____ Bleeding disorder	_____ Headache	_____ Prothesis	_____ Tuberculosis
_____ Cancer	_____ Heart problems	_____ Scoliosis	_____ Ulcers/GERD
_____ Cerebral Palsy	_____ Hearing problems	_____ Severe Acne	_____ Vision problems
_____ Chicken Pox	_____ High blood pressure	_____ Sinus problems	_____ Weight problems

Describe any other health problems. _____
List any surgeries. _____
List any activity restrictions. _____
List daily medications. _____

Will student need to take medication at school? YES _____ NO _____

Will student need special health care procedures at school? YES _____ NO _____
Describe procedure. _____

DOES YOUR CHILD HAVE SEVERE REACTIONS TO BEE STINGS REQUIRING AN INJECTION OF MEDICATION?
YES _____ NO _____

PHYSICIAN _____ TELEPHONE _____

IN THE EVENT OF SERIOUS ACCIDENT OR ILLNESS, EMERGENCY MEDICAL SERVICES WILL BE CALLED.
THE STUDENT WILL THEN BE TRANSPORTED TO THE NEAREST HOSPITAL AT THE PARENT'S EXPENSE.

This information, along with my child's immunization record, may be shared with school personnel, wellness center personnel, and other health professionals pertinent to my child's health. My child's immunization record can be shared with the West Virginia Statewide Immunization Information System.

SIGNATURE (PARENT/GUARDIAN) _____ DATE _____

FERPA/HIPAA CONSENT

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION BETWEEN DENTAL/MEDICALPROVIDERS and SCHOOL DISTRICTS

Completion of this document authorizes the disclosure and/or use of individually identifiable health information, as set forth below, consistent with Federal laws (including HIPAA) concerning the privacy of such information. Failure to provide all information requested may invalidate this authorization.

USE AND DISCLOSURE INFORMATION:

Patient/Student Name: _____
Last First MI Date of Birth

I, the undersigned, do hereby authorize (name of agency and/or health care providers):
(1) _____ (2) _____
to provide health information from the above-named child's medical record to and from:

Clay County Schools — School District to Which Disclosure is Made
PO Box 120 Clay, West Virginia 25043 — Address / City and State / Zip Code
Alicia Johnson, Jennifer Moore, or Lindsay Schoolcraft — Contact Person at School District
304 587 4266 — Area Code and Telephone Number

The disclosure of health information is required for the following purpose:

_____

Requested information shall be limited to the following:

☐ All minimum necessary health information; or ☐ Disease-specific information as described:

_____

DURATION:

This authorization shall become effective immediately and shall remain in effect until_____(enter date) or for one year from the date of signature, if no date entered.

RESTRICTIONS:

Law prohibits the Requestor from making further disclosure of my health information unless the Requestor obtains another authorization form from me or unless such disclosure is specifically required or permitted by law.

YOUR RIGHTS:

I understand that I have the following rights with respect to this Authorization: *I may revoke this Authorization at any time. My revocation must be in writing, signed by me or on my behalf, and delivered to the school district/health care agencies/persons listed above. My revocation will be effective upon receipt, but will not be effective to the extent that the Requestor or others have acted in reliance to this Authorization.*

RE-DISCLOSURE:

I understand that the Requestor (School District) will protect this information as prescribed by the Family Educational Rights and Privacy Act (FERPA) and that the information becomes part of the student's educational record. The information will be shared with individuals working at or with the School District for the purpose of providing safe, appropriate and least restrictive educational settings and school health services and programs.

I have a right to receive a copy of this Authorization. Signing this Authorization may be required in order for this student to obtain appropriate services in the educational setting.

APPROVAL:

_____ _____ _____
Printed Name Signature Date

_____ _____
Relationship to Patient/Student Area Code and Telephone Number